

10127

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>3 Month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glasgow Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sallie</b> Middle <b>Finley</b> Last <b>Bobbitt</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 14 1877</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Wooldland P. Finley</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs Finley Bobbitt</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aplastic anemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Senility</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gangrene right foot, embolus pretibial artery</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I for Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 11, 1958</b> , to <b>Sept. 22, 1958</b> , that I last saw the deceased alive on <b>Sept. 22, 1958</b> , and that death occurred at <b>2:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Dr. W. H. Hanks</b>				M.D. <b>Cambridge, Maryland</b> <b>Oct. 18, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>sept 25, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Church Hill Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral service Cambridge, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10128

CERTIFICATE OF DEATH

10119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Moody</b> Last <b>Bradley Sr.</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>30,</b> Year <b>19 58</b>			
5. SEX <b>MALE</b> <b>White</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 6, 1886</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mobil Oil Co</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>William P Bradley</b>				14. MOTHER'S MAIDEN NAME <b>Edith LeCompte</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>089 01 0823</b>		17. INFORMANT <b>Mrs Edith Bradley</b>		Address <b>Cambridge Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>The metastatic Carcinoma</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma Colon</b> 7 yrs DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/10</b> , 19 <b>56</b> , to <b>9/30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9/30</b> , 19 <b>58</b> , and that death occurred at <b>10 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. H. Hanks</b>				ADDRESS (Street, city or town, state) <b>104 Locust St Cambridge Md.</b>			
DATE SIGNED <b>10/2/58</b>							
PHYSICIAN'S NAME (Type) <b>W. H. HANKS</b>				<b>CAMBRIDGE MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>October 2, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Men. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service Cambridge Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

CERTIFICATE OF DEATH

11138

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF FUNERAL HOME [Illegible]		NAME OF MINISTER [Illegible]	
NAME OF NEXT OF KIN [Illegible]		NAME OF WITNESS [Illegible]		NAME OF REGISTRAR [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF FUNERAL HOME [Illegible]		SIGNATURE OF MINISTER [Illegible]	
SIGNATURE OF NEXT OF KIN [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10129

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10120

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dprchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	c. LENGTH OF STAY IN lb <b>All life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5 Center St.</b>		d. STREET ADDRESS <b>1 5 Center St.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Wannetta</b> Middle <b>Lucile</b> Last <b>Brannock</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>8</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/21/58</b>
9. AGE (In years last birthday) yrs. <b>1</b> Months <b>18</b> Days <b>18</b>		IF UNDER 1 YEAR Hours <b>18</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carl Edward Brannock</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Cornish.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Elizabeth Brannock, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity (Cause unknown)</b> <b>776 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/8/58</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/9/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Dor. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hebert A. ...</b>		24a. REC'D BY REGISTRAR <b>SEP 16 '58</b>	
ADDRESS <b>Cambridge, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH OFFICE

CITY OF BOSTON

DECEASED

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

CAUSE OF DEATH

MANNER OF DEATH

TOXICOLOGY

LABORATORY

POSTMORTEM

ORGANS

CELLS

STAINING

DISSECTION

REPORT

REMARKS

SIGNATURE

DATE

PLACE

TIME

WITNESSES

NOTARY

FILE

INDEX

RECORD

DEPT.

HEALTH

COMMISSIONER

STATE

MASSACHUSETTS

BOSTON

DEATH

CERTIFICATE

NO. 1



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10130

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David Lee Garri</u>		4. DATE OF DEATH <u>9/14/58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/22/1936</u>
9. AGE (In years, last birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
13. FATHER'S NAME <u>John J. Garri</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Ms Margaret Garri, Hurlock, Md.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Injury</u> 823x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture base of skull</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 Hrs</u> <u>7 Hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was driver of car which overturned.</u>	
19a. TIME OF INJURY Month, Day, Year <u>4:15 A.M. 9/14/58</u>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 331</u>		20b. (City or town) (County) (State) <u>Nr. Hurlock, Dor, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22b. LOCATION (City, town, or county) (State) <u>Hurlock, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10122

10131

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Woolfords			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hosp.				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William R. Gillis				4. DATE OF DEATH Month Day Year Sept. 3, 19 58			
5. SEX Male White*	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1884	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Lumber Mill		10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Leonard G Gillis				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) N o		16. SOCIAL SECURITY NO. 244 03 5343		17. INFORMANT Miss Ruth Gillis		Address Woolford Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary artery insufficiency weeks DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cholelithiasis and cholecolithiasis INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <del>Sept 1</del> Sept 3, 1958, to <del>Sept 3</del> Sept 3, 1958, that I last saw the deceased alive on <del>Sept 3</del> Sept 3, 1958, and that death occurred at <del>M</del> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Lewie M. Burdette M.D. 1 Locust St. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Lewis M. Burdette Cambridge, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Old Trinity		22d. LOCATION (City, town, or county) (State) Church Creek Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service				ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Evans			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10132

## CERTIFICATE OF DEATH

Reg. Dist. No.

10123

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hosp.</b>				d. STREET ADDRESS <b>17 Cedar Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>T.</b> Last <b>Goslin</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>7</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1892</b>		9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Seaford</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Thomas Goslin</b>				14. MOTHER'S MAIDEN NAME <b>Emily Hurley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Bessie Goslin Cambridge Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 yr.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9/4</b> 19 <b>58</b> , to <b>9/7</b> 19 <b>58</b> , that I last saw the deceased alive on <b>9/7</b> 19 <b>58</b> , and that death occurred at <b>7:40</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 Race St. Cambridge, Md.</b> DATE SIGNED <b>9/8/58</b>							
ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D.				DATE SIGNED <b>9/8/58</b>			
PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>				DATE SIGNED <b>9/8/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 9, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Men Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service</b>				ADDRESS <b>Cambridge Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 10 '58</b>	
24b. REGISTRAR'S SIGNATURE							



10133

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>				d. STREET ADDRESS <b>Choptank</b>			
3. NAME OF DECEASED (Type or print) First <b>Brenda</b> Middle <b>Joyce</b> Last <b>Goswellen</b>				4. DATE OF DEATH Month <b>September</b> Day <b>16</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 17, 1948</b>		9. AGE (In years last birthday) <b>10</b> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>N. Elton Goswellen</b>				14. MOTHER'S MAIDEN NAME <b>Myrtle D. Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>N. Elton Goswellen, Preston, Md., R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Acute Diabetes Mellitus</b> DUE TO (c) <b>4 days</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month <b>9</b>	Day <b>15</b>	Year <b>1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>104 Locust</b>	(County) <b>CAMBRIDGE Md</b>
21. I certify that I attended the deceased from <b>9/15</b> , 19 <b>58</b> , to <b>9/16</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9/16</b> , 19 <b>58</b> , and that death occurred at <b>2:50 PM</b> , from the causes and on the date stated above.							DATE SIGNED <b>9/18/58</b>
ACTUAL SIGNATURE <b>W. J. HARKS</b>				ADDRESS (Street, city or town, state) <b>104 Locust</b>			
PHYSICIAN'S NAME (Type) <b>W. H. HARKS</b>				ADDRESS <b>CAMBRIDGE Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 19, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Choptank Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Choptank, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR <b>SEP 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 10, 1912	
AGE		SEX	
65		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTHPLACE		PLACE OF BIRTH	
Maryland		Baltimore, Maryland	
DATE OF BIRTH		PLACE OF BIRTH	
JANUARY 10, 1847		Baltimore, Maryland	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Failure		Natural	
DISEASE		SYMPTOMS	
Hypertension		Shortness of breath, swelling of feet	
PREVIOUS ILLNESS		DATE OF ONSET	
None		JANUARY 5, 1912	
TREATMENT		DATE OF DEATH	
None		JANUARY 10, 1912	
SIGNATURE OF PHYSICIAN		DATE	
J. H. HARRIS		JANUARY 10, 1912	
SIGNATURE OF WITNESSES		DATE	
J. H. HARRIS		JANUARY 10, 1912	
SIGNATURE OF DECEASED		DATE	
J. H. HARRIS		JANUARY 10, 1912	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY OF IT IS TO BE SENT TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDES.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10134

## CERTIFICATE OF DEATH

10125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>13</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>158 Race Street</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b> d. STREET ADDRESS <b>158 Race Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rannie G. Gray</b>		4. DATE OF DEATH Month Day Year <b>Sept. 6 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	9. AGE (In years last birthday) <b>67</b> IF UNDER 1 YEAR Months Days Hours Min. <b>6 19 58</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>	
13. FATHER'S NAME <b>Abihu Gray</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ewell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mildred A. Gray Cambridge, Md.</b>	
17. INFORMANT <b>Mildred A. Gray Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA (PROSTATE)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>15 MONTH</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 FEB 19 58</b> to <b>6 SEPT 19 58</b> that I last saw the deceased alive on <b>6 SEPT 19 58</b> , and that death occurred at <b>4 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>105 CHURCH ST</b> DATE SIGNED <b>6 SEPT 58</b> ACTUAL SIGNATURE <b>Walter E. Gunby Jr.</b> PHYSICIAN'S NAME (Type) <b>WALTER E. GUNBY JR. CAMBRIDGE MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 8, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service Cambridge Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 10 '58</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur E. Smith</i>			



10135

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN TB <b>34 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>				d. STREET ADDRESS <b>10 Pleasant Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elder</b> Middle <b>Raymond</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>Sept. 14, 1958</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1882</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Painter retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William A. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Clarise Flowers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Cosey Johnson, West End Ave., Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HT. DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>UNDET</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/17</b> , 19 <b>58</b> to <b>9/14</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9/13</b> , 19 <b>58</b> , and that death occurred at <b>3:00 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Alfred R. Maryanov</b>				ADDRESS (Street, city or town, state) <b>136 RACE ST</b> DATE SIGNED <b>9/15/58</b>			
PHYSICIAN'S NAME (Type) <b>ALFRED R. MARYANOV</b>				<b>CAMBRIDGE, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 16, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Remith R. Shoult</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 17 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. S. K...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

## CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CITY OR TOWN [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF CLERK [Faint text]		SIGNATURE OF [Faint text] [Faint text]	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10147** **CERTIFICATE OF DEATH**

10127

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>XXXXXXXXXXXX Wilcomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsborg 228-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Lemuel James Jones</b>		4. DATE OF DEATH <b>Sept 19 1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 14, 1883</b>
		9. AGE (In years, lost birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Berlin L S A</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13. FATHER'S NAME <b>William J. Jones</b>	14. MOTHER'S MAIDEN NAME <b>Mary Coffin</b>
--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Mrs. Betty P. Jones (Wife) Parsonsborg Eastern Shore State Hospital records Maryland</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>UNK</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)

21. I certify that I attended the deceased from <b>July 7, 1958</b> , to <b>Sept 19, 1958</b> , that I last saw the deceased alive on <b>Sept 18, 1958</b> , and that death occurred at <b>2:35 AM</b> , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <b>E.S.S.H., Cambridge, Md.</b>	DATE SIGNED <b>Sept 19 1958</b>
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D.	
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept 21, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsonsborg Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Parsonsborg, Maryland</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>	ADDRESS <b>SALISBURY MARYLAND</b>	24a. REC'D BY REGISTRAR DATE <b>SEP 22 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Annex 2. 1958</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED <b>JOHN J. LEONARD</b>		2. SEX <b>MALE</b>		3. AGE <b>38</b>	
4. DATE OF DEATH <b>NOV 15 1923</b>		5. TIME OF DEATH <b>10:30 AM</b>		6. PLACE OF DEATH <b>HOME</b>	
7. CAUSE OF DEATH <b>HEART DISEASE</b>		8. MANNER OF DEATH <b>NATURAL</b>		9. PLACE OF BIRTH <b>NEW YORK</b>	
10. OCCUPATION <b>CLERK</b>		11. MARITAL STATUS <b>MARRIED</b>		12. EDUCATION <b>HIGH SCHOOL</b>	
13. PREVIOUS ILLNESS <b>NO</b>		14. PRESENT ILLNESS <b>NO</b>		15. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
16. SIGNATURE OF WITNESSES <b>JOHN J. LEONARD</b>		17. SIGNATURE OF PHYSICIAN <b>JOHN J. LEONARD</b>		18. SIGNATURE OF CORONER <b>JOHN J. LEONARD</b>	
19. SIGNATURE OF REGISTRAR <b>JOHN J. LEONARD</b>		20. SIGNATURE OF CLERK <b>JOHN J. LEONARD</b>		21. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
22. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		23. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		24. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
25. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		26. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		27. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
28. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		29. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		30. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
31. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		32. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		33. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
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37. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		38. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		39. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
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46. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		47. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		48. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
49. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		50. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		51. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
52. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		53. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		54. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
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64. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		65. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		66. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
67. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		68. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		69. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
70. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		71. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		72. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
73. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		74. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		75. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
76. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		77. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		78. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
79. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		80. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		81. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
82. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		83. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		84. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
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88. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		89. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		90. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
91. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		92. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		93. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
94. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		95. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		96. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
97. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		98. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		99. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	
100. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		101. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>		102. SIGNATURE OF DECEASED <b>JOHN J. LEONARD</b>	

TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10136

## CERTIFICATE OF DEATH

Reg. Dist. No.

10128

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>3yrs, 2mos</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTERN SHORE STATE HOSPITAL</b>		d. STREET ADDRESS <b>W. OCEAN CITY</b> <b>23X-2</b>	
3. NAME OF DECEASED (Type or print) First <b>LOVEY</b> Middle <b>LYNCH</b> Last <b>LYNCH</b>		4. DATE OF DEATH Month <b>SEPT</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN ONLEY</b>		14. MOTHER'S MAIDEN NAME <b>FANNIE HICKMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>421.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSION</b> DUE TO (c) <b>GEN'L ARTERIO-SCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APR 24</b> , 19 <b>57</b> , to <b>SEPT. 1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>SEPT. 1</b> , 19 <b>58</b> , and that death occurred at <b>8:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CAMBRIDGE, MARYLAND</b> DATE SIGNED <b>SEPT. 1, 1958</b> ACTUAL SIGNATURE <b>Harry J. Crawford</b> M.D. <b>HARRY J. CRAWFORD</b> PHYSICIAN'S NAME (Type) <b>HARRY J. CRAWFORD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-5-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>EUSEB GREEN</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BURKEAGE</b> <b>Ruth A. Burkeage</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 5 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10137

Item 11, Film 254, 1-13-60, E5

10129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dorchester</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b>			
c. LENGTH OF STAY IN 1b <b>3 yrs.</b>				d. STREET ADDRESS <b>Box 173</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Isabella</b>			4. DATE OF DEATH <b>Sept. 20 1958</b>				
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. B. DATE OF BIRTH <b>5/19/1873</b>			9. AGE (In years last birthday) <b>85</b> yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland Ireland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William McClain</b>				
14. MOTHER'S MAIDEN NAME <b>Mary McClain</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT Address <b>Hospital Record</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary-Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-Scleroses</b> DUE TO (c) <b>Hypertension</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 24, 1957</b> , to <b>Sept. 20, 1958</b> , that I last saw the deceased alive on <b>Sept. 20, 1958</b> , and that death occurred at <b>10.40PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cambridge, Maryland</b> DATE SIGNED <b>Sept. 20, 1958</b>							
ACTUAL SIGNATURE <b>Harry J. Crawford</b>			M.D. <b>Cambridge, Maryland</b>				
PHYSICIAN'S NAME (Type) <b>Harry J. Crawford</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/25/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Mariah</b>		22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	



CERTIFICATE OF DEATH

10337

1. NAME OF DECEASED JAMES J. HENRY		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 10-15-1898		5. PLACE OF BIRTH Boston, Mass.	
6. OCCUPATION Clerk		7. MARITAL STATUS Married		8. COLOR White		9. HEIGHT 5' 8"		10. WEIGHT 150 lbs.	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH 10-25-1943		14. TIME OF DEATH 10:30 AM		15. SIGNATURE OF REGISTRAR [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF NEXT OF KIN [Signature]		18. SIGNATURE OF PHYSICIAN [Signature]		19. SIGNATURE OF CLERK [Signature]		20. SIGNATURE OF WITNESS [Signature]	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF NEXT OF KIN [Signature]		23. SIGNATURE OF PHYSICIAN [Signature]		24. SIGNATURE OF CLERK [Signature]		25. SIGNATURE OF WITNESS [Signature]	
26. SIGNATURE OF DECEASED [Signature]		27. SIGNATURE OF NEXT OF KIN [Signature]		28. SIGNATURE OF PHYSICIAN [Signature]		29. SIGNATURE OF CLERK [Signature]		30. SIGNATURE OF WITNESS [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF NEXT OF KIN [Signature]		33. SIGNATURE OF PHYSICIAN [Signature]		34. SIGNATURE OF CLERK [Signature]		35. SIGNATURE OF WITNESS [Signature]	
36. SIGNATURE OF DECEASED [Signature]		37. SIGNATURE OF NEXT OF KIN [Signature]		38. SIGNATURE OF PHYSICIAN [Signature]		39. SIGNATURE OF CLERK [Signature]		40. SIGNATURE OF WITNESS [Signature]	
41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF NEXT OF KIN [Signature]		43. SIGNATURE OF PHYSICIAN [Signature]		44. SIGNATURE OF CLERK [Signature]		45. SIGNATURE OF WITNESS [Signature]	
46. SIGNATURE OF DECEASED [Signature]		47. SIGNATURE OF NEXT OF KIN [Signature]		48. SIGNATURE OF PHYSICIAN [Signature]		49. SIGNATURE OF CLERK [Signature]		50. SIGNATURE OF WITNESS [Signature]	
51. SIGNATURE OF DECEASED [Signature]		52. SIGNATURE OF NEXT OF KIN [Signature]		53. SIGNATURE OF PHYSICIAN [Signature]		54. SIGNATURE OF CLERK [Signature]		55. SIGNATURE OF WITNESS [Signature]	
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61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF NEXT OF KIN [Signature]		63. SIGNATURE OF PHYSICIAN [Signature]		64. SIGNATURE OF CLERK [Signature]		65. SIGNATURE OF WITNESS [Signature]	
66. SIGNATURE OF DECEASED [Signature]		67. SIGNATURE OF NEXT OF KIN [Signature]		68. SIGNATURE OF PHYSICIAN [Signature]		69. SIGNATURE OF CLERK [Signature]		70. SIGNATURE OF WITNESS [Signature]	
71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF NEXT OF KIN [Signature]		73. SIGNATURE OF PHYSICIAN [Signature]		74. SIGNATURE OF CLERK [Signature]		75. SIGNATURE OF WITNESS [Signature]	
76. SIGNATURE OF DECEASED [Signature]		77. SIGNATURE OF NEXT OF KIN [Signature]		78. SIGNATURE OF PHYSICIAN [Signature]		79. SIGNATURE OF CLERK [Signature]		80. SIGNATURE OF WITNESS [Signature]	
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86. SIGNATURE OF DECEASED [Signature]		87. SIGNATURE OF NEXT OF KIN [Signature]		88. SIGNATURE OF PHYSICIAN [Signature]		89. SIGNATURE OF CLERK [Signature]		90. SIGNATURE OF WITNESS [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF NEXT OF KIN [Signature]		93. SIGNATURE OF PHYSICIAN [Signature]		94. SIGNATURE OF CLERK [Signature]		95. SIGNATURE OF WITNESS [Signature]	
96. SIGNATURE OF DECEASED [Signature]		97. SIGNATURE OF NEXT OF KIN [Signature]		98. SIGNATURE OF PHYSICIAN [Signature]		99. SIGNATURE OF CLERK [Signature]		100. SIGNATURE OF WITNESS [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10138

## CERTIFICATE OF DEATH

10130

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glasgow Nursing Home</b>				e. STREET ADDRESS <b>R F D 3</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Duncan</b> Middle <b>Leverton</b> Last <b>Noble</b>				<b>4. DATE OF DEATH</b> Month <b>Sept</b> Day <b>26</b> , Year <b>19 58</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Feb. 25, 1878</b>	
<b>9. AGE</b> (In years last birthday) <b>80 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Months Days Hours Min.		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>	
<b>13. FATHER'S NAME</b> <b>Jacob L. Noble</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Manie Travers</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>Mrs Duncan Noble Cambridge Md.</b>			
<b>17. INFORMANT</b> <b>Mrs Duncan Noble Cambridge Md.</b>				<b>Address</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxic Myocarditis</b> DUE TO <b>Multiple Decubitus ulcers</b> (b) <b>Postero lateral Sclerosis Pericardium</b> DUE TO <b>Postero lateral Sclerosis Pericardium</b> (c) <b>Postero lateral Sclerosis Pericardium</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 weeks</b> <b>6 mos</b> <b>12 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. Month. Day. Year 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>				<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I attended the deceased from 10/11, 1947, to 9/26, 1958, that I last saw the deceased alive on 9/26, 1958, and that death occurred at 1:30 P. M. from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) <b>10450 Cass St Cambridge Md.</b> DATE SIGNED <b>9/27/58</b>							
<b>ACTUAL SIGNATURE</b> <b>W. H. HANKS</b> M.D.				<b>PHYSICIAN'S NAME (Type)</b> <b>W. H. HANKS</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Sept 28, 1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Christ Church Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Cambridge Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Le Compe Funeral Home</b>				<b>ADDRESS</b> <b>Cambridge Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>SEP 30 58</b>	
<b>24b. REGISTRAR'S SIGNATURE</b>							

CERTIFICATE OF DEATH

10-1-32

MD 200-100

<p>1. NAME OF DECEASED JOHN J. JONES</p>		<p>2. SEX Male</p>		<p>3. AGE 45</p>		<p>4. DATE OF BIRTH 10-1-1887</p>	
<p>5. PLACE OF BIRTH BALTIMORE, MD</p>		<p>6. OCCUPATION Carpenter</p>		<p>7. MARITAL STATUS Married</p>		<p>8. DATE OF DEATH 10-1-32</p>	
<p>9. CAUSE OF DEATH Heart Disease</p>		<p>10. PLACE OF DEATH Home</p>		<p>11. SIGNATURE OF PHYSICIAN J. J. Jones</p>		<p>12. SIGNATURE OF REGISTRAR J. J. Jones</p>	
<p>13. NAME OF PHYSICIAN J. J. Jones</p>		<p>14. NAME OF REGISTRAR J. J. Jones</p>		<p>15. NAME OF WITNESS J. J. Jones</p>		<p>16. NAME OF WITNESS J. J. Jones</p>	
<p>17. NAME OF WITNESS J. J. Jones</p>		<p>18. NAME OF WITNESS J. J. Jones</p>		<p>19. NAME OF WITNESS J. J. Jones</p>		<p>20. NAME OF WITNESS J. J. Jones</p>	
<p>21. NAME OF WITNESS J. J. Jones</p>		<p>22. NAME OF WITNESS J. J. Jones</p>		<p>23. NAME OF WITNESS J. J. Jones</p>		<p>24. NAME OF WITNESS J. J. Jones</p>	
<p>25. NAME OF WITNESS J. J. Jones</p>		<p>26. NAME OF WITNESS J. J. Jones</p>		<p>27. NAME OF WITNESS J. J. Jones</p>		<p>28. NAME OF WITNESS J. J. Jones</p>	
<p>29. NAME OF WITNESS J. J. Jones</p>		<p>30. NAME OF WITNESS J. J. Jones</p>		<p>31. NAME OF WITNESS J. J. Jones</p>		<p>32. NAME OF WITNESS J. J. Jones</p>	
<p>33. NAME OF WITNESS J. J. Jones</p>		<p>34. NAME OF WITNESS J. J. Jones</p>		<p>35. NAME OF WITNESS J. J. Jones</p>		<p>36. NAME OF WITNESS J. J. Jones</p>	
<p>37. NAME OF WITNESS J. J. Jones</p>		<p>38. NAME OF WITNESS J. J. Jones</p>		<p>39. NAME OF WITNESS J. J. Jones</p>		<p>40. NAME OF WITNESS J. J. Jones</p>	
<p>41. NAME OF WITNESS J. J. Jones</p>		<p>42. NAME OF WITNESS J. J. Jones</p>		<p>43. NAME OF WITNESS J. J. Jones</p>		<p>44. NAME OF WITNESS J. J. Jones</p>	
<p>45. NAME OF WITNESS J. J. Jones</p>		<p>46. NAME OF WITNESS J. J. Jones</p>		<p>47. NAME OF WITNESS J. J. Jones</p>		<p>48. NAME OF WITNESS J. J. Jones</p>	
<p>49. NAME OF WITNESS J. J. Jones</p>		<p>50. NAME OF WITNESS J. J. Jones</p>		<p>51. NAME OF WITNESS J. J. Jones</p>		<p>52. NAME OF WITNESS J. J. Jones</p>	
<p>53. NAME OF WITNESS J. J. Jones</p>		<p>54. NAME OF WITNESS J. J. Jones</p>		<p>55. NAME OF WITNESS J. J. Jones</p>		<p>56. NAME OF WITNESS J. J. Jones</p>	
<p>57. NAME OF WITNESS J. J. Jones</p>		<p>58. NAME OF WITNESS J. J. Jones</p>		<p>59. NAME OF WITNESS J. J. Jones</p>		<p>60. NAME OF WITNESS J. J. Jones</p>	
<p>61. NAME OF WITNESS J. J. Jones</p>		<p>62. NAME OF WITNESS J. J. Jones</p>		<p>63. NAME OF WITNESS J. J. Jones</p>		<p>64. NAME OF WITNESS J. J. Jones</p>	
<p>65. NAME OF WITNESS J. J. Jones</p>		<p>66. NAME OF WITNESS J. J. Jones</p>		<p>67. NAME OF WITNESS J. J. Jones</p>		<p>68. NAME OF WITNESS J. J. Jones</p>	
<p>69. NAME OF WITNESS J. J. Jones</p>		<p>70. NAME OF WITNESS J. J. Jones</p>		<p>71. NAME OF WITNESS J. J. Jones</p>		<p>72. NAME OF WITNESS J. J. Jones</p>	
<p>73. NAME OF WITNESS J. J. Jones</p>		<p>74. NAME OF WITNESS J. J. Jones</p>		<p>75. NAME OF WITNESS J. J. Jones</p>		<p>76. NAME OF WITNESS J. J. Jones</p>	
<p>77. NAME OF WITNESS J. J. Jones</p>		<p>78. NAME OF WITNESS J. J. Jones</p>		<p>79. NAME OF WITNESS J. J. Jones</p>		<p>80. NAME OF WITNESS J. J. Jones</p>	
<p>81. NAME OF WITNESS J. J. Jones</p>		<p>82. NAME OF WITNESS J. J. Jones</p>		<p>83. NAME OF WITNESS J. J. Jones</p>		<p>84. NAME OF WITNESS J. J. Jones</p>	
<p>85. NAME OF WITNESS J. J. Jones</p>		<p>86. NAME OF WITNESS J. J. Jones</p>		<p>87. NAME OF WITNESS J. J. Jones</p>		<p>88. NAME OF WITNESS J. J. Jones</p>	
<p>89. NAME OF WITNESS J. J. Jones</p>		<p>90. NAME OF WITNESS J. J. Jones</p>		<p>91. NAME OF WITNESS J. J. Jones</p>		<p>92. NAME OF WITNESS J. J. Jones</p>	
<p>93. NAME OF WITNESS J. J. Jones</p>		<p>94. NAME OF WITNESS J. J. Jones</p>		<p>95. NAME OF WITNESS J. J. Jones</p>		<p>96. NAME OF WITNESS J. J. Jones</p>	
<p>97. NAME OF WITNESS J. J. Jones</p>		<p>98. NAME OF WITNESS J. J. Jones</p>		<p>99. NAME OF WITNESS J. J. Jones</p>		<p>100. NAME OF WITNESS J. J. Jones</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10139

CERTIFICATE OF DEATH

10132

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1 Hambrooks Boulevard</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Orion</b> Middle <b>Pritchett</b> Last <b>111</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 11 1945</b>
9. AGE (In years last birthday) <b>14</b> yrs.		IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.	IF UNDER 24 HRS. Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US A</b>	
13. FATHER'S NAME <b>Orion Pritchett Jr.</b> <del>Betty*Hugh*Fountain*</del>		14. MOTHER'S MAIDEN NAME <b>Betty Hugh Fountain</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Orion Pritchett Jr.</b>		Address <b>Cambridge Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Broncho-pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gargoylism</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>12yrs. +</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6-30-50</b> , 19__, to <b>9-26-58</b> , 19__, that I lost saw the deceased olive on <b>9-25-58</b> , 19__, and that death occurred at <b>9:35 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>15 Locust st. Cambridge, Maryland</b> DATE SIGNED <b>9-27-58</b>			
ACTUAL SIGNATURE <b>Eldridge H. Wolff</b>		M.D. <b>15 Locust st. Cambridge, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Eldridge H. Wolff, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept 28, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Men, Park.</b>	22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service</b>		24a. REC'D BY REGISTRAR <b>SEP 30 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Carbur S. House</b>





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10148

## CERTIFICATE OF DEATH

Reg. Dist. No. 10133

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eldorado - Rural</b>				c. LENGTH OF STAY IN 1b <b>3 weeks</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eldorado - Rural</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eldorado-Sharpstown Road</b>			
d. STREET ADDRESS <b>Eldorado-Sharpstown Road</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Magdalene</b> Last <b>Robinson</b>				4. DATE OF DEATH Month <b>September</b> Day <b>25</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 5, 1920</b>	
9. AGE (In years last birthday) yrs. <b>37</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Dorsey F. Evans</b>				14. MOTHER'S MAIDEN NAME <b>Lavinia Cannon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-18-2259</b>		17. INFORMANT <b>Harvey E. Robinson, Federalsburg, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>191X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma Cordis</b> DUE TO (c) <b>1957</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b> <b>1957</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9-22, 1958</b> , to <b>9-22, 1958</b> , that I last saw the deceased alive on <b>9-22, 1958</b> , and that death occurred at <b>12:10 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. E. Lennon</b> M.D.				ADDRESS (Street, city or town, state) <b>Federalsburg, Maryland</b> DATE SIGNED <b>9-27-58</b>			
PHYSICIAN'S NAME (Type) <b>W. E. Lennon, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10134

10140

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Conoway</u> Last <u>Sampson</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 25, 1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Perry Slacum</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Slacum</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>217-30-8603</u>				17. INFORMANT <u>Rosalie Pelson, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>March 27</u> , 19 <u>56</u> , to <u>September</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 25</u> , 19 <u>58</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u>			
DATE SIGNED <u>9-27-58</u>				PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/28/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. S. S. S.</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10135

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Md. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James E. Stanley</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/6/23</b>
9. AGE (In years last birthday) <b>35 yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saw mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Caroles Stanley</b>		14. MOTHER'S MAIDEN NAME <b>Manie Mortique</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records Cambridge, Md. Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial injuries</b> <b>822X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple fractures skull.</b> DUE TO (c)</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>Abt. 11hr.</b> <b>11 Hrs.</b></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Tire blew out, truck overturned, was passenger in same.</b>	
20c. TIME OF INJURY Month, Day, Year <b>8:30 a.m. 9/26/58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 336</b>		20f. (City or town) (County) (State) <b>Golden Hill, Dor. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>9/29/58</b>	
EXAMINER'S NAME (Type) <b>Dr. John Mace, Jr.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/29/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Airey</b>		22d. LOCATION (City, town, or county) (State) <b>Airey, Dorchester, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leon W. Henry</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE OCT 3 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



FOR STATE  
HEALTH DEPT.



THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON HAS BEEN EXAMINED BY THE PHYSICIAN IN CHARGE OF THE STATE HOSPITAL AND FOUND TO BE A PATIENT OF THE HOSPITAL.

STATE OF NEW YORK  
COUNTY OF [ ]  
IN SENATE  
January 1, 1906

REPORT OF THE PHYSICIAN IN CHARGE OF THE STATE HOSPITAL  
ON THE CONDITION OF THE PATIENTS DURING THE YEAR 1905

NAME OF PATIENT [ ]  
AGE [ ]  
SEX [ ]  
DATE OF ADMISSION [ ]  
DATE OF DISCHARGE [ ]  
PLACE OF BIRTH [ ]  
OCCUPATION [ ]  
RELIGION [ ]  
EDUCATION [ ]  
PREVIOUS ILLNESS [ ]  
PRESENT ILLNESS [ ]  
CAUSE OF DEATH [ ]  
MANNER OF DEATH [ ]  
POST-MORTEM EXAMINATION [ ]  
FINDINGS [ ]  
REMARKS [ ]

10142

CERTIFICATE OF DEATH

10136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>13</b> <b>Cambridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Etha</b> Middle <b>Todd</b> Last <b>Todd</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>6</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 13, 1881</b>		9. AGE (In years last birthday) yrs. <b>77</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Miss Marice Todd</b>		Address <b>Cambridge Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute renal failure.</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic nephritis</b> DUE TO (c) <b>Coronary Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>3 wks.</b> <b>6 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Intestinal Obstruction. Dilated uterus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>8/29</b> , 19 <b>57</b> , to <b>9/5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9/5</b> , 19 <b>58</b> , and that death occurred at <b>12:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 Raw St. Cambridge Md.</b> DATE SIGNED <b>9/6/58</b>							
ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D.		PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov, M.D. Cambridge, Md.</b>					
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 8, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Men. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service</b>				ADDRESS <b>Cambridge Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 10 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10143

## CERTIFICATE OF DEATH

Reg. Dist. No.

10137

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>			
c. LENGTH OF STAY IN (b) <u>1 1/2 weeks</u>				d. STREET ADDRESS <u>Cambridge Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jesse James Todd</u>				4. DATE OF DEATH Month Day Year <u>9 / 6 / 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/28/1887</u>	
9. AGE (In years last birthday) yrs. <u>71</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Own Business</u>		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Todd</u>				14. MOTHER'S MAIDEN NAME <u>Emma</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Roger Todd, Secretary, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 DAYS</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/27/58</u> 19 <u>58</u> , to <u>9/6</u> 19 <u>58</u> , that I last saw the deceased alive on <u>9/5</u> 19 <u>58</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> M.D.				ADDRESS (Street, city or town, state) <u>136 RACE ST</u>		DATE SIGNED <u>9/8/58</u>	
PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV</u>				CITY OR TOWN <u>CAMBRIDGE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9/8/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u> ADDRESS <u>6 N. Market</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY OR TOWN	
COUNTY		STATE	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL	
SIGNATURE OF MINISTER OF GOSPEL		SIGNATURE OF CLERGYMAN	
SIGNATURE OF CHURCH OFFICIAL		SIGNATURE OF FUNERAL HOME	
SIGNATURE OF HEALTH OFFICIAL		SIGNATURE OF VITALS OFFICIAL	
SIGNATURE OF DEATH CERTIFICATE OFFICIAL		SIGNATURE OF DEATH CERTIFICATE OFFICIAL	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICIALS OF THE CITY OR TOWN IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.



10144

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>30 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>		e. STREET ADDRESS <b>7 Holland Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Gilliss</b> Last <b>Walker</b>		4. DATE OF DEATH <b>Sept. 13, 1958</b> Month <b>Sept.</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14, 1886</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>71</b> Days <b>19</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Months <b>71</b> Days <b>19</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor in Shirt Factory</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cambridge R.D.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John C. Walker</b>		14. MOTHER'S MAIDEN NAME <b>Miranda Gilliss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-20-3622</b>	
17. INFORMANT <b>Mrs. Clara Walker, 7 Holland Ave., Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma pharynx</b> <b>148X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with metastases</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/10</b> , 19 <b>58</b> , to <b>9/13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9/13</b> , 19 <b>58</b> , and that death occurred at <b>9:15 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. H. Hanks</b>		ADDRESS (Street, city or town, state) <b>104 Locust Cambridge, Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. H. H. Hanks</b>		DATE SIGNED <b>9/17/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 16, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel R. Thomas</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REPORTED BY  
MAY 19 1964

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Office of Registrar	
13. Name of Informant		14. Relationship to Deceased		15. Signature of Informant	
16. Name of Informant		17. Relationship to Deceased		18. Signature of Informant	
19. Name of Informant		20. Relationship to Deceased		21. Signature of Informant	
22. Name of Informant		23. Relationship to Deceased		24. Signature of Informant	
25. Name of Informant		26. Relationship to Deceased		27. Signature of Informant	
28. Name of Informant		29. Relationship to Deceased		30. Signature of Informant	
31. Name of Informant		32. Relationship to Deceased		33. Signature of Informant	
34. Name of Informant		35. Relationship to Deceased		36. Signature of Informant	
37. Name of Informant		38. Relationship to Deceased		39. Signature of Informant	
40. Name of Informant		41. Relationship to Deceased		42. Signature of Informant	
43. Name of Informant		44. Relationship to Deceased		45. Signature of Informant	
46. Name of Informant		47. Relationship to Deceased		48. Signature of Informant	
49. Name of Informant		50. Relationship to Deceased		51. Signature of Informant	
52. Name of Informant		53. Relationship to Deceased		54. Signature of Informant	
55. Name of Informant		56. Relationship to Deceased		57. Signature of Informant	
58. Name of Informant		59. Relationship to Deceased		60. Signature of Informant	
61. Name of Informant		62. Relationship to Deceased		63. Signature of Informant	
64. Name of Informant		65. Relationship to Deceased		66. Signature of Informant	
67. Name of Informant		68. Relationship to Deceased		69. Signature of Informant	
70. Name of Informant		71. Relationship to Deceased		72. Signature of Informant	
73. Name of Informant		74. Relationship to Deceased		75. Signature of Informant	
76. Name of Informant		77. Relationship to Deceased		78. Signature of Informant	
79. Name of Informant		80. Relationship to Deceased		81. Signature of Informant	
82. Name of Informant		83. Relationship to Deceased		84. Signature of Informant	
85. Name of Informant		86. Relationship to Deceased		87. Signature of Informant	
88. Name of Informant		89. Relationship to Deceased		90. Signature of Informant	
91. Name of Informant		92. Relationship to Deceased		93. Signature of Informant	
94. Name of Informant		95. Relationship to Deceased		96. Signature of Informant	
97. Name of Informant		98. Relationship to Deceased		99. Signature of Informant	
100. Name of Informant		101. Relationship to Deceased		102. Signature of Informant	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10139

10145

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Maryland Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>			
				d. STREET ADDRESS <u>1 220 Muir Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Ward</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 2, 1898</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Thomas Ward</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-----</u>			
17. INFORMANT <u>Jehu Wilson, Cambridge, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-----</u> DUE TO (c) <u>-----</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 1, 1958</u> , to <u>Sept 19, 1958</u> , that I last saw the deceased alive on <u>September 19, 1958</u> , and that death occurred at <u>5 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u>			
DATE SIGNED <u>9-22-58</u>							
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kiana</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 24 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>							

CERTIFICATE OF DEATH

<p>1. Name of deceased: <b>John William Oakes</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Date of birth: <b>Aug. 18, 1898</b></p>		<p>4. Place of birth: <b>USA</b></p>	
<p>5. Date of death: <b>Dec. 1, 1938</b></p>		<p>6. Place of death: <b>Johns Hopkins Hospital, Baltimore, Md.</b></p>	
<p>7. Cause of death: <b>Myocardial infarction</b></p>		<p>8. Immediate cause: <b>Coronary artery disease</b></p>	
<p>9. Duration of illness: <b>2 weeks</b></p>		<p>10. Date of admission to hospital: <b>Nov. 15, 1938</b></p>	
<p>11. Name of attending physician: <b>Dr. J. H. Oakes</b></p>		<p>12. Name of hospital: <b>Johns Hopkins Hospital</b></p>	
<p>13. Name of registrar: <b>John W. Oakes</b></p>		<p>14. Name of informant: <b>John W. Oakes</b></p>	
<p>15. Signature of registrar: <i>[Signature]</i></p>		<p>16. Signature of informant: <i>[Signature]</i></p>	
<p>17. Date of registration: <b>Dec. 1, 1938</b></p>		<p>18. Place of registration: <b>Baltimore, Md.</b></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10149

CERTIFICATE OF DEATH

Reg. Dist. No.

10140

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galestown</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.#3(Seaford, Del.)</b>		d. STREET ADDRESS <b>R.D.# 3(Seaford, Del.)</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ULYSSES</b> Middle <b>GARFIELD</b> Last <b>WRIGHT</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>23rd</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>29</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Wright</b>		14. MOTHER'S MAIDEN NAME <b>Ann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mrs. Mabel V. Wright (Wife) R.D.# 3-Seaford Del.) Galestown, Maryland</b>	
17. INFORMANT <b>Mrs. Mabel V. Wright (Wife) R.D.# 3-Seaford Del.) Galestown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.1 DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Disease</b> DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/4</b> , 19 <b>58</b> to <b>9/24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9/24</b> , 19 <b>58</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Laurel, Delaware</b> DATE SIGNED <b>Sept. 24th /1958</b>			
ACTUAL SIGNATURE <b>Charles M. Moyer</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Charles M. Moyer</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 26/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>SEP 25 '58</b> DATE <b></b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Brand</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DECEASED Name John W. Jones		DATE OF DEATH April 15, 1955	
PLACE OF DEATH Home		CITY Baltimore	
COUNTY Baltimore		STATE Maryland	
AGE 65		SEX Male	
MARRIAGE Married		EDUCATION High School	
OCCUPATION Retired		RELIGION Methodist	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Coronary Artery Disease	
FUNDAMENTAL CAUSE Atherosclerosis		PRE-EXISTING DISEASES Hypertension, Diabetes	
SIGNS AND SYMPTOMS Chest pain, shortness of breath		TREATMENT None	
HISTORY Long history of heart disease		FAMILY HISTORY None	
SOCIAL HISTORY Nonsmoker, no alcohol		HISTORICAL DATA None	
PHYSICAL EXAMINATION Normal		LABORATORY DATA None	
PATHOLOGICAL DATA None		MICROSCOPIC DATA None	
GROSS DATA None		HISTOCHEMICAL DATA None	
IMMUNOLOGICAL DATA None		CYTOLOGICAL DATA None	
RADIOLOGICAL DATA None		OTHER DATA None	

RECEIVED  
MAY 10 1955  
BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10146 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

10141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>48 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>		d. STREET ADDRESS <b>206 Hayward Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>206 Hayward Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Francis</b> Last <b>Wroten</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14, 1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cambridge, R.D.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George W. Wroten</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Kirwan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Henrietta H. Wroten, 206 Hayward St., Camb., Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic nephritis</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>10 yrs</b> <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/16</b> , 19 <b>58</b> to <b>9/22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9/22</b> , 19 <b>58</b> , and that death occurred at <b>4:55 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>136 Race St. Cambridge Md</b>	
ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D.		DATE SIGNED <b>9/23/58</b>	
PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>		<b>Cambridge Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 24, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Benjamin R. Thomas</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hawk</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
Date of Certificate		Place of Death		City		County	
State		Zip Code		Telephone Number		Hospital or Institution	
Physician's Address		Physician's Telephone		Physician's License No.		Physician's Signature	
Registrar's Address		Registrar's Telephone		Registrar's License No.		Registrar's Signature	
Coroner's Address		Coroner's Telephone		Coroner's License No.		Coroner's Signature	
Medical Examiner's Address		Medical Examiner's Telephone		Medical Examiner's License No.		Medical Examiner's Signature	